Maryland Department of Health and Mental Hygiene

Mental Hygiene Administration

Spring Grove Hospital Center – Dix Building

55 Wade Avenue – Catonsville, Maryland 21228

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, MD, Secretary

Brian Hepburn, M.D., Executive Director

In accordance with the requirements of Health-General Article, §10-714, please complete the following information. *NOTICE: Effective 10/1/09, for purposes of reporting of deaths, "program or facility" means an inpatient or residential treatment setting, residential crisis service, group home, residential rehabilitation program, or psychiatric rehabilitation program (see House Bill 412 – 2009). Only the aforementioned programs/facilities must comply with this reporting requirement.*

A. Demographics

- Name of Decedent: (Last, First) _____
- Decedent's Gender: ☐ Male ☐ Female
- Decedent's Date of Birth _____
- Decedent's Age _____
- MA #_____
- SS #_____
- Date of Discovery of Death: _____
- Decedent's place of Residence at Time of Death (Street Address, City and State): _____
- Place where the body was found (e.g. bedroom, bathroom, field, unknown): _____
- If death occurred in a place other than the residence of the decedent, the location of the body at the time of discovery: _____
- Name of the person who took custody of the body: _____
- Name of the person evaluating the death, if known: _____
- Autopsy to be performed? ☐Yes ☐ No ☐Unknown
- Name of Decedent's Next Of Kin or Legal Guardian (If Known): _____

  Address: _____ Telephone Number: _____

B. Clinical/Community Provider Information.

- Name of Facility/Program Reporting the Death: _____
- Address of Facility/Program (include county): _____
- Name & Telephone Number of Person Completing Form:_____
- Date Admitted/Enrolled with provider: _____
- Date last seen by Provider _____
- Treating Psychiatrist and telephone number: _____

Decedent's Name (please print): _____

- Primary Therapist and telephone number: _____
- Medical Care Physician and telephone number: _____
- Case Manager and telephone number: _____
- Services decedent received prior to death: ☐ OMHC ☐ PRP ☐ RRP

  ☐ Mental Health Vocational Program ☐ Mobile Treatment ☐ Crisis Response

  ☐ Residential Crisis ☐ Assisted Living ☐ IOP ☐ PHP ☐ RTC ☐ Respite

  ☐ Case Management ☐ Inpatient, psychiatric ☐ Inpatient, medical

  ☐ Other _____

  - **If decedent was hospitalized within 30 days of death, please indicate where and for what reason:** _____

C. Diagnoses. List **all medical/psychiatric** diagnoses known to be current during the 30 days prior to death (**DO NOT USE CPT CODES!**)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

D. Medications. List decedent's current medications, including PRN's, and if known, those prescribed by other providers.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

E. Allergies: _____ ☐ None Known

F. History of Aggression/Violence toward Self or Others: _____

G. Legal Involvement, if any: _____

H. Possible Cause of Death*.

☐ Natural ☐ Act of violence ☐ Suicide ☐ Casualty

☐ Suddenly, if the deceased was in apparent good health ☐ Suspicious or unusual manner

Decedent's Name (please print): _____

- Please provide information believed relevant to the above cause(s) of death. Attach separate page if needed. If information is obtained via an obituary notice, please attach a copy of the obituary.

I. Notifications. The initial report may be (1) oral, if followed by a written report within 5 working days from date of the death, or (2) written. If the possible cause of death is believed to be anything but 'natural', the provider shall report the death, in addition to all parties listed below, the medical examiner.

Please check notifications performed.

- Immediate Notification Required:
  - ☐ Law Enforcement Official in the jurisdiction in which the death occurred; and
  - ☐ The Secretary of the Department of Health and Mental Hygiene.
- Notification required by close of business of the next working day:
  - ☐ The Director of the Mental Hygiene Administration;
  - ☐ The health officer in the jurisdiction where the death occurred; and
  - ☐ The designated State protection and advocacy system.
- Other notification:
  - ☐ The medical examiner (if the cause of death is believed to be other than 'natural')

J. Contact Information.

Printed Name & Title of Person Submitting Form: _____

Telephone Number: _____

Signature of Individual Submitting Form: _____

CONFIDENTIALITY NOTICE

This document contains confidential information. Disclosure of this document could be a violation of the Maryland Confidentiality of Medical Records law. **REDISCLOSURE IS STRICTLY PROHIBITED**, unless made pursuant to HG §4-302(d) of the Annotated Code of Maryland.

IF YOU RECEIVE THIS DOCUMENT IN ERROR, PLEASE IMMEDIATELY NOTIFY THE SENDER TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENT(S).